

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015231

STATE FILE NUMBER

FILED MAY 8 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. 3572

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS Mo</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LUTHERAN Hosp.</u>		Length of stay in 1b	d. STREET ADDRESS <u>8002 MATHILDA</u>
			(If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>MOLLY H. KENKEL</u>			4. DATE OF DEATH <u>APRIL 9 1959</u>		
First	Middle	Last	Month	Day	Year

5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 16 1916</u>	9. AGE (In years last birthday) <u>42</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUILDING & CONTRACTING</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>	11. BIRTHPLACE (City and state or country) <u>MINNESOTA</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>JAMES RADINA</u>	13b. MOTHER'S MAIDEN NAME <u>AGNES DEDERA</u>	13c. NAME OF HUSBAND OR WIFE <u>RAY H. KENKEL</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>488-01-2293</u>	17. INFORMANT <u>RAY H. KENKEL</u> Address <u>8002 MATHILDA</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Metastatic Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mos.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Carcinoma of Rectum</u>	<u>1 yr.</u>
	DUE TO (c) <u>154x</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <u>Aug. 2 1943</u> to <u>April 9, 1959</u> and last saw ^{her} alive on <u>April 8, 1959</u> Death occurred at <u>6:00 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Frank A. Bailey</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>3108 So. Grand Blvd.</u>	22c. DATE SIGNED <u>4/9/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>Apr. 11 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION</u>	23d. LOCATION (City, town, or county) <u>ST. LOUIS Mo</u>	(Store)
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24. FUNERAL DIRECTOR <u>Thomas Stutte</u> ADDRESS <u>2906 Travis</u>	25. DATE RECD. BY LOCAL REG. <u>APR 10 59</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

PR 6-1073

12 30 - 5 30 P.M. *St. Louis*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Eleana Province*

Licensed Embalmer No. *3103*

P. O. Address *Jennings*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.